## PATIENT INFORMATION

**PLEASE FILL OUT COMPLETELY**

**AND RETURN TO OFFICE**


**7 Hill Gastroenterology, PA**

**3256 S. Pine Avenue Ocala FL. 34471**

**Office: (352) 401-1919**

**Fax: (352) 401-1870**

**Today's Date** _____

**YOUR SSN:** _____ _____ _____

**Name: (Miss) (Mrs.) (Mr.)** _____ _____ _____

**LAST** **FIRST** **MIDDLE**

**DATE OF BIRTH:** _____ **SEX (CIRCLE ONE): Female Male**

**ADDRESS:** _____ _____ _____ _____

**STREET** **CITY** **STATE** **ZIP**

**TELEPHONE: Home:**_____ **Work:**_____ **Cell:** _____

**ETHNICITY (CIRCLE ONE):** **ASIAN/PACIFIC ISLANDER** **BLACK** **CAUCASIAN** **HISPANIC**

**AMERICAN/ALASKAN NATIVE** **MUTHUALLY DEFINED** **OTHER**

**MARITAL STATUS (CIRCLE ONE):** SINGLE MARRIED DIVORCED LEGALLY SEPARATED LIFE PARTNER

**IF MARRIED, PARTNER'NAME:**_____

**HOW MANY CHILDRESN DO YOU HAVE?**_____ **AGES:**_____

**HIGHEST LEVEL OF EDUCATION RECEIVED:** _____

**IN THE EVENT OF AN EMERGENCY, PROVIDE US THE NAME AND NUMBER OF WHOM WE SHOULD CALL:**

NAME:_____ PHONE: _____

NAME:_____ PHONE: _____

## YOUR PHYSICIANS INCLUDING SPECIALISTS & PHYSCHIATRISTS

**REFERRING PHYSICIAN NAME:**_____ **PHONE:** _____

**PRIMARY PHYSICIAN NAME:** _____ **PHONE:**_____

**OTHER DOCTORS :** _____ **PHONE:**_____

**OTHER DOCTORS :** _____ **PHONE:**_____

## INSURED INFORMATION:

**NAME**_____ **RELATIONSHIP TO PATIENT** _____

**DOB**_____ **SSN:**_____ **PHONE:**_____

**ADDRESS**_____

**PRIMARY INSURANCE** _____**ID#**_____**GROUP**_____

**PHARMACY NAME**_____**PHONE:**_____

**Patient's Name**

**Last :**_____

**First:** _____

**Date:** _____

7 Hill Gastroenterology, P.A.
www.7hillgastroflorida.com

# PATIENT DIAGNOSTICS FORM

**REFERRED BY** _____

**REASON FOR VISIT/CHIEF COMPLAINT**_____

**HOW LONG HAVE SYMPTOMS BEEN PRESENT?**_____

**TYPE OF PAIN: SHARP DULL BURNING ACHING CRAMPING OTHER**_____

**LOCATION: EPIGASTRIC RIGHT LOWER LEFT LOWER RIGHT UPPER LEFT UPPER**

**DOES PAIN RADIATE TO ANY PART OF THE BODY? YES NO RADIATES TO:**_____

**FREQUENCY OF PAIN** _____ **DURATION OF PAIN:**_____

**DOES PAIN CHANGE WITH:**
(CIRCLE ALL THAT APPLY)

| EATING | BOWEL MOVEMENTS | ANTACIDS | STRESS | REST |
|---|---|---|---|---|
| WORSE | WORSE | WORSE | WORSE | WORSE |
| BETTER | BETTER | BETTER | BETTER | BETTER |
| NO CHANGE | NO CHANGE | NO CHANGE | NO CHANGE | NO CHANGE |

**HAVE YOU EXPEREINCED ANY OF THE FOLLOWING** (CIRCLE ALL THAT APPLY):

**NAUSEA EXCESSIVE GAS BLOATING BELCHING RECTAL PAIN/DISCOMFORT RECTAL BLEEDING WEIGHT LOSS**
**VOMITING FEVER CHEST PAIN DARK/BLACK STOOLS BLOOD ON TOILET PAPER BLOOD IN STOOLS WEIGHT GAIN**

| | | | |
|---|---|---|---|
| **Does pain wake you from sleep?** | **YES NO** | IF "YES", FOR HOW LONG? | |
| **Are you experiencing unusual stress?** | **YES NO** | IF "YES", FOR HOW LONG? | |
| **Are you experiencing Heartburn?** | **YES NO** | IF "YES", FOR HOW LONG? | |
| **Does treatment improve heartburn?** | **YES NO** | **WHAT MEDICATIONS TRIED?** | |
| **Do you have difficulty swallowing?** | **YES NO** | **LIQUIDS SOLIDS BOTH** | |

**BOWEL MOVEMENTS**: **REGULAR CONSTIPATION DIARRHEA ALTERNATING FREQUENCY**: _____

**CIRCLE WHICH SUBSTANCES YOU USE AND DESCRIBE HOW MUCH YOU USE OF EACH**

| | CAFFEINE | TOBACCO | ALCOHOL | _____ | _____ |
|---|---|---|---|---|---|
| How much? | | | | | |
| For how many | | | | | |

**Patient's Name**

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**First:** _____

**Date:** _____

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# PATIENT PHYSICAL HISTORY FORM

**AGE:** _____ **SEX: F M** **DATE OF LAST PHYISCAL EXAMINATION:**_____

| LIST ALL MEDICATIONS /HERBS / SUPPLEMENTS YOU ARE TAKING | DOSAGE |
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| LIST KNOWN DRUG ALLERGIES | OTHER ALLERGIES: |
|---|---|
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| SURGICAL HISTORY | Yes / No (CIRCLE) | Date | OTHER SURGERIES (LIST BELOW) | Date |
|---|---|---|---|---|
| GALLBLADDER | YES NO | | | |
| STOMACH ULCERS | YES NO | | | |
| APPENDECTOMY | YES NO | | | |
| HYSTERECTOMY | YES NO | | | |
| HEART SURGERY | YES NO | | | |
| ORTHOPEDICS | YES NO | | | |
| C-SECTION | YES NO | | | |

| FAMILY HISTORY | | RELATIONSHIP | AGE AT TIME OF DIAGNOSIS |
|---|---|---|---|
| COLON CANCER | YES NO | | |
| COLON POLYPS | YES NO | | |
| ULCERATIVE COLITIS | YES NO | | |
| CHROHN'S DISEASE | YES NO | | |
| PEPTIC ULCER | YES NO | | |
| HEART DISEASE | YES NO | | |
| DIABETES | YES NO | | |
| HIGH BLOOD PRESSURE | YES NO | | |
| LIVER DISEASE | YES NO | | |

| OTHER DISEASE | RELATIONSHIP | AGE AT TIME OF DIAGNOSIS |
|---|---|---|
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# MEDICARE/INSURANCE INFORMATION

**DO YOU HAVE MEDICARE/MEDICAID INSURANCE? (CIRCLE ONE) YES NO**

**IF YES, WHAT IS YOUR MEDICARE/MEDICAID NUMBER?** _____

**IF NO, DO YOU HAVE ANOTHER INSURANCE CARRIER? (CIRCLE ONE) YES NO**

**NAME OF YOUR INSURANCE CARRIER** _____

**INSURANCE CARRIER ADDRESS** _____

**GROUP #** _____ **ID#** _____

**SUBSCRIBER'S NAME:** _____ **DOB:**_____ **SSN:** _____-_____-_____

**DO YOU HAVE A SECONDARY INSURANCE CARRIER?**_____

**INSURANCE CARRIER ADDRESS** _____

**GROUP #** _____ **ID#** _____

**SUBSCRIBER'S NAME:** _____ **DOB:**_____ **SSN:** _____-_____-_____

**DOES YOU INSURANCE REQUIRE PRE-ADMISSION CERTIFICATION? (CIRCLE ONE) YES NO**

**IF YES, PLEASE PROVIDE US WITH THE TELEPHONE NUMBER (**_____**)** _____- _____

**Medicare Law requires that we determine if your medical services might be covered by another insurer. In order to assist us in correct billing procedures, please answer the following questions:**

1. **Is your illness due to:**
   - **A. A work-related accident/condition? YES NO**
   - **B. An automobile accident? YES NO**
   - **C. The fault of another party? YES NO**
2. **Are you eligible for coverage under the Veterans Administration? YES NO**
3. **Are you a student: YES NO If yes, are you a Full-Time Student? YES NO**
4. **Are you employed? YES NO**
   - **If "Yes", provide employer's name** _____
   - **Employers address** _____
   - **Employer's phone:** _____
   - **If "No", please provide date of retirement if applicable:** _____

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# MEDICARE/INSURANCE INFORMATION (CON'T)

5. **Is your spouse employed? YES NO**

**If "Yes", please provide us with your spouse's name:** _____

**Spouse's Employer's Name:** _____

**Spouse's Employer's Address:** _____

**If "No", please provide date of retirement if applicable:** _____

***PLEASE READ CAREFULLY In consideration for services rendered by 7 Hill Gastroenterology, P.A., I hereby agree to release the information requested, as needed, by my Insurance company and assign insurance benefits to 7 Hill Gastroenterology, P.A.. I further agree to be solely responsible for any balances my insurance carrier does not pay.**

**THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT.**

**SIGNATURE:** _____ **DATE:** _____

**RELATIONSHIP TO PATIENT:** _____

**I request that payment of authorized Medicaid benefits be made on my behalf to 7 Hill Gastroenterology, P.A. for any services rendered by 7 Hill Gastroenterology, P.A.**

**SIGNATURE:** _____ **DATE:** _____

***PROTECTING YOUR MEDICAL HEALTH INFORMATION:*** **Please list the names of family members, and/or friends with whom we may share your medical information and/or lab results. DUE TO PRIVACY LAWS, WE WILL NOT GIVE ANY INFORMATION TO ANYONE WHO IS NOT ON THIS LIST!**

**PLEASE LIST THE PEOPLE WE MAY CALL WITH YOUR MEDICAL INFORMATION:**

**NAME:**_____ **PHONE:(____)**_____

**NAME:**_____ **PHONE:(____)**_____

**NAME:**_____ **PHONE:(____)**_____

**MAY WE MAIL INFORMATION TO YOU?** YES NO **MAY WE LEAVE A MESSAGE ON YOUR PHONE?** YES NO

***NOTIFICATION OF TEST RESULTS:*** **Pleas call our office if you have not been notified of a test result by 14 days from date of having test performed.**

***YOUR SIGNATURE:*** _____ **DATE:**_____